

District Nursing Leadership

Key points

1. District nurses who work as advanced practitioners as part of teams, do not feel the burden of responsibility felt by team-leading DNs.
2. Participating in decision-making with team members from a distance helps to reduce the burden of responsibility felt by DNs and may promote autonomy.
3. Shared responsibility can be achieved if there is mutuality, reciprocity and a focus on personal resourcefulness
4. District nurses do not appear to recognise or value their ability to be creative problem-solvers
5. District Nurses adopt directive forms of leadership in order to feel able to shoulder their perceived burden of responsibility, but adopting facilitative leadership approaches will create conditions of empowerment.
6. Leadership development across all levels of healthcare is a policy imperative and this study suggests there is un-tapped potential in the district nursing workforce.

Reflective questions 3-5

1. Reflecting on how you engage with patients and families and promote health and well-being, how can you use these skills and attributes in your leadership role?
2. What does shared responsibility mean to you and how could you and your team achieve this in practice?
3. What do you think are enabling questions and what are the most useful ones in helping others to make decision or find solutions?
4. Reflecting on your practice, what examples of creative problem-solving do you recognise?

Introduction

The role of community nursing is receiving increased attention across the globe due to increasing demands for home and community-based services. In many countries, there is a reliance on the undergraduate programmes to equip nurses for multiple work contexts, whereas in others, such as the United Kingdom (UK), Iceland and Sweden, community nurses require post-registration preparation. This paper focuses on research in district nursing in the UK. The findings will be of interest in other countries as, despite the increasing demand for care delivered at home, there is a growing community workforce shortage which has been blamed on a number of factors including professional appeal, preparation and a lack of leadership (Maybin et al. 2016; Van Iersel et al., 2018; While, 2006). A lack of leadership has implications on quality care delivery (Haycock-Stuart & Kean, 2012).

Background

Since the Declaration of Alma Ata in 1978 there has been a paradigm shift in thinking about health (World Health Organization (WHO), 2008). This has been evident in integrating health and social care in developed countries and the commitment across the globe to keep people at home or as close to home as possible, avoiding unnecessary hospital admissions (WHO 2016). According to the International Centre for Human Resources in Nursing (2012), placing community nurses at the centre of this change poses challenges in terms of recruitment, skill-mix and leadership, resulting in demand for community nursing exceeding available capacity. One example of the resulting pressures can be seen in the UK. A recent report commissioned by the Kings Fund (Maybin, et al. 2016) identified inadequate resources and a continuing void of leadership as key challenges to recruitment and retention. This lack of leadership resulting in a concentration on task-focused care and deprioritising of activities associated with positive staff

well-being. To date, however, little attention has been given to community nurses' own understandings of leadership.

Community Nursing Leadership

Currie and Hill (2012) suggest the continued challenges to recruitment and retention include the nature of the work environment, with issues of stress, safety, and leadership being central concerns. Twigg and McCullough (2014) reviewed the literature to elicit strategies that support retention of nurses. They identified creating and enhancing positive, empowering work environments and leadership as key strategies. Empowerment was also a theme emphasized in the 2016 WHO Global Strategy on Human Resources for Health: Workforce: 2030. Within this strategy, an objective to build leadership capacity at all levels in healthcare was set, with specific aim of developing competent, motivated and empowered workforce to deliver quality care.

Leadership theories focus on the leader, the follower, their interaction and the context. Within community nursing there appears to be little known internationally about this aspect of practice resulting in a lack of clarity around the concept of leadership. Indeed, it has been suggested that community nurses are inward looking, 'followers' rather than leaders (Kean, et al. 2011). In that study, leadership was perceived as change, although the vision for this emerged from a vision set in policy, rather than the leader or team's vision. Other writers have argued that the leadership commonly found in community nursing is not underpinned by any specific theoretical model. For example, in a study of leadership within district and public health nursing teams, Cameron et al. (2012) found that those working in these teams emphasized the influence of context on leadership, co-location being a factor in the leader-follower dynamic. Caseload-holding district nurses were concerned with creating a happy team and management of day-to-day delivery of service. Those responsible for leading and managing a number of teams were

more focused on influencing and improving patient care than on team dynamics. A recent study of community nurses by Carlin and Chesters (2018) found that senior nurse managers identified leadership and management as important parts of the community nurse role but that perceptions of leadership varied considerably. Although several participants claimed to draw upon a transformational leadership approach their descriptions of leadership failed readily to match up with key theoretical constructs of transformational theory. Moreover, it is also argued that the day-to-day demands of community nursing and the systems within which these operate, effectively subsume even the best leadership intentions of those working in the field, precluding the successful operation of a model such as that of transformational leadership (Fast & Rankin, 2018). For such reasons Hutchinson and Jackson (2013) argue that, in contrast to the critical examination of leadership found elsewhere, within nursing there has been too much reliance on theories that do not readily reflect nursing in practice: what is needed is a different understanding of nursing leadership that is ‘cognisant of the complexities and challenges of the healthcare environment’.

Previous research therefore does not point to any consistent understanding of the leadership or leadership preparation required of the community nurse role. There is a need for awareness of how community nurses experience leadership in practice, to understand the opportunities and challenges and resultant impact. To contribute to such an understanding, this paper reports findings from a study which explored the experiences of community nurses in one particular setting, that of Scotland, UK. The aim of the study was to gain insight into district nurses’ experiences and how they make sense of the leadership aspect of their role.

Method

Design

The data for this study comes from a larger project that examined the experiences and understandings of district nurses of all aspects of their role. This study utilized the theoretical framework of Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009; Smith & Osborn, 2008) to explore how district nurses made sense of the leadership elements of their practice. IPA foregrounds detailed examination of individuals' own understandings of their experiences, thereby allowing for the development of theory that is grounded in those experiences. Drawing on the theoretical background of phenomenology and hermeneutics, IPA requires the researcher to interpret the participants' sense-making of '*being-in-context*' (Heidegger, 1995; Smith & Osborn, 2008). In this way, IPA is 'double-hermeneutic' (Smith, et al. 2009), allowing the researcher to interpret participants' own interpretations of their experiences. The outcome is one of detailed examination of the participants' understandings of phenomena within a specific context, here that of community nursing practice.

Participants

Samples in IPA studies comprise participants who represent a particular perspective of the phenomenon (Smith, 2007). Due to its idiographic nature, IPA in any instance relies on recruitment of a small sample of participants who can provide rich data that are immediately relevant to the research aim. District Nurses in one healthcare organisation in Scotland, UK were invited to participate by the Director of Nursing. She sent information sheets to district nurses in team leading or advance practice roles, which included researcher contact details. The researcher was not known to any of the participants or their managers. Interested district nurses volunteered to be part of the study. Sampling was conducted purposively to achieve a

District Nursing Leadership

homogenous group. Ten district nurses, expressed an interest in being part of the study. Eight were recruited. Workload was given as the reason for the other two interested nurses not taking part. The team leading and advanced practice district nurses all had Specialist Practitioner Qualifications (NMC 2001). Team-leading district nurses held management roles, managing their caseload and the team. The skill-mixed teams had a median size of five. Their caseloads were of adult patients with a range of health care needs, but with an emphasis on acute care episodes, managing long-term conditions and end of life care. Advanced Practitioners managed and coordinated care, but not caseloads or teams. They adopted a shared leadership approach with other practitioners in multi-disciplinary teams. The focus of their care was frail older people and rehabilitation. All participants were female with between 7 and 26 years of experience in their role. The district nurses' average caseload was approximately 96, whereas advanced practitioners co-managed a caseload of approximately 110 patients

Data collection

Semi-structured interviews were undertaken by the first author in participants' workplaces. No one else was present. The interviews were guided by a series of open-ended questions that invited participants to tell the stories of their experiences and were designed to probe into '*everydayness*' and to encourage dialogue (Smith, Flowers, & Larkin, 2009). These questions were pilot-tested. Interviews lasted between 45 minutes and 75 minutes and were audio-recorded. Following interviews, participants were invited to keep an audio-journal for a minimum of five days to allow the researcher to gain further insight into the phenomenon (Nicholl, 2010). Interviews and journals were subsequently transcribed verbatim by the first author, and pseudonyms were substituted for participants' names to ensure anonymity.

Ethical considerations

Ethical approval was granted from the University Ethics Committee and Research and Development Approval was granted by the participating National Health Service Health Board. The study was conducted in accordance with the principles set out in the Health & Care Professions Council (HCPC) Standards of Conduct, Performance and Ethics (2016).

Data analysis

The data were analysed using recognized principles of IPA (Smith, Flowers, & Larkin 2009). Within IPA, analysis proceeds on an iterative and recursive basis not a linear one. This enables the researcher to engage with the data on multiple levels while moving from description to interpretation of the data. In the present case, each participant's interview and audio-journal transcript were analysed simultaneously. The data were coded for the participants' descriptions of leadership with all potentially relevant passages being selected out for closer analysis. These passages were read and re-read to increase familiarity with the data. Through this process, coding progressed from exploratory to conceptual coding. Attention thereafter turned to identification of indicators of meaning. Initial indicators were grouped into emerging themes that were then compared with indicators of meaning across all transcripts. Initial themes were developed to take account also of what initially appeared to be deviant cases but which provided further insights into the participants' understandings. Analysis continued on an iterative basis until no further themes emerged and the three themes that had been identified provided the most useful analytic fit with the participants' descriptions of their experiences. Analysis was initially conducted by the first author and the final analysis was discussed and agreed by all authors.

Rigour

Rigour was ensured by adopting four criteria for quality in qualitative research as proposed by Yardley (2000) namely sensitivity to context, commitment and rigour, transparency

and coherence, impact and importance, as applied to IPA studies by Smith, Flowers and Larkin (2009). The study displayed *sensitivity to context* by focusing on the participants' experiences of being district nurses, and *commitment and rigour* in the close attention paid to data collection and subsequent thoroughness of analysis. This report of our research is designed to demonstrate *transparency* and *coherence* in conveying the detail of how the study was conducted and the findings derived. The final conclusions of this paper subsequently meet the final criterion of displaying *impact and importance* in providing giving an insight into district nurses' leadership experiences. The COREQ checklist has been used to report this research systematically (see supplementary file 1).

Findings

The three sub-themes identified through analysis were, *being conductor of the orchestra*, *balancing the clinical part and the business part* and *shouldering the weight of responsibility*. Each theme is discussed in turn below. Pseudonyms have been used, consistent with others' reporting IPA studies.

Being conductor of the orchestra

Participants consistently described their experiences of leading and coordinating inter-agency health and social care teams as *being conductor of the orchestra*. Team leading participants described being proactive and prepared, supporting and ensuring teams were fit for purpose. Advanced practitioners did not describe a team development role. For all, their skills in managing care were described as navigating a path of complexity towards solutions in a range of health and social care problems. The context within which participants were working appeared to pose ethical dilemmas, adding to the complexity. There were examples given of the current political ethos of enabling self-management and shared decision-making. Policy implementation

involves patients being given budgets to manage their own care, leading to differing expectations. This context was perceived to be impacting on staff morale, their ability to manage risk and the complexity of decision-making.

Many accounts detailed care coordination, where participants were *'going the extra mile,'* (Jane), *'making it work'* (Denise) for patients. Denise's story was of coordinating care for a man who was dying and helping his partner find acceptable ways to help him remain at home:

The gentleman himself is deteriorating by the day [] we've got a hospital bed in the living room. He doesn't like the mattress. We've changed that. [] we're really just trying everything to make things as easy as..... a situation like that can never be easy. But we are doing everything in our power to enable him to have the time at home that he wants to have.....' (Denise)

Participants' approach was seeking shared decision-making and being anticipatory, *'being a bit of a detective'* (Fay). Accounts conveyed engaging with and involving carers in decisions and their skill in knowing when they require additional support. Participants described their anticipatory approach as knowing the bigger picture, *"dealing with the bigger picture to meet unmet needs"* (Jane). Steph felt this was an aspect of specialist expertise, not shared with staff nurses, (nurses without the SPQ). Some participants described different situations where decisions were deferred in their absence because they thought some staff nurses avoided taking responsibility. It is unclear whether this was due to role expectation, or a lack of a shared vision of care. However, Denise was the only participant who described participation in decision-making at a distance, helping staff nurses problem-solve through enabling questions. Denise, leader of the largest team adopted a staff development approach:

'My role is guiding them now, letting them talk through their concerns, adding my 'take'

on it, then guiding them to be able to make [decisions] we know where to send that to, who to get involved with it [] It's having the confidence' (Denise)

Balancing the clinical part and the business part

Participants described balancing the '*clinical part and business parts*' of their role. For team-leading community nurses, they described a re-focusing of their role to one with an emphasis on management. It was described by Mary as, '*the office job*' and Jane as the '*unseen stuff that you can't quantify that folk don't get about our job*'. Ali reflected on her role as a caseload manager which involved care and staff management, highlighting an increased volume of work with increasingly limited resources. The balance she described, as '*ensuring safe, effective, person-centred care is delivered by her team*', whilst being the '*troubleshooters*' and '*administrator*'. She also highlighted her ability to think strategically by maintaining an overview of the service and available resources:

'We have a responsibility to the population as a whole to utilise the resources that we've got available to us.....You have to have an overview of the caseload. You have to be able to work within the resources available to you and to have cognisance that these resources are finite. If patients and or families have unrealistic expectations then I think it is the team leader's role to negotiate, to educate certainly and to mediate probably' (Ali).

Achieving a balance between delivering the service and managing the resources was, however, seen as a recurring challenge. Participants described a significant amount of '*juggling the balls in the air*' (Jane), '*chasing our tails*' (Denise) and wearing, '*many hats and guises*' (Ali). The clinical part was conveyed as their expertise in managing clinical care. This extended

beyond their own clinical practice to that of others (Katherine). They had overall responsibility for delivering the service, caseload and team management:

'You're trying to pull it [care management] all together at the end of the day and keep your clinical governance right and making sure care that is provided by everyone is good and of a high quality and meets all the patients' needs and that involves a lot of time sitting at the computer. A lot of paperwork. A lot of phone calls, documenting the phone calls and being late most days really' (Steph).

Shouldering the weight of responsibility

All team-leading participants perceived the weight of responsibility for clinical and management aspects of the role as burdensome. Advanced Practitioners did not share this feeling. This was attributed to their role as caseload manager and the reliance on care delivered by others e.g. members of the nursing team and broader inter-agency team. Participants described working within an organizational system where the expectations of them are high, but unboundaried. There was a sense of worry about the decisions they were making. Participants referred to responsibility for autonomous decision-making for patients and families as 'scary' (Jane) and *'lonely....because you are making some pretty big decisions'* (Steph). Mary described challenges of being *'just yourself'*. *You've not got a fancy bag of tricks or equipment.'* Despite examples of being problem-solvers, the data were littered with negative language which appeared to demonstrate little value on their ability to be creative in their problem-solving. Rather than naming and owning this expertise, they emphasized feelings related to inappropriate referrals. Whilst Jane viewed this positively: *'Our ethos is always we will do it if there isn't anyone else to do it'* (Jane), others not so, the phrase *'dumping ground'* (Mary and Steph), was

mentioned more than once. Discharge was a time when three participants (*Mary, Jane, Ali*) described '*picking up the pieces*' as a way of conveying a sense of doing the work of other people. Despite this rhetoric, there was a strong commitment to meet patient and family needs. When the lack of resources were a barrier, they filled the gap undertaking such activities as collecting prescriptions, moving furniture, checking on patients whose care package was inadequate. Perceived lack of support and resource were also highlighted as contributing factors to stress, despite organization movement towards health and social care integration. Steph conveyed her political awareness:

'It's very frustrating because you want to provide the care for someone in their home. We can do that but we can do the technical nursing side. We can monitor pain.....you know we can do syringe drivers. We can do chemotherapy at home. But when a little old lady is needing someone just to be with them so that they don't fall, it's ridiculous because they're having to go into hospital' (Steph).

There is evidence of directive leadership in accounts, where the weight of responsibility is felt. This is reflected in the terms used by some participants, particularly those in team leading roles, such as being '*authoritarian*', (Jane), '*a control freak*' (Denise), '*bossy boots*' (Steph). Participants described trying to keep their experience hidden from others, giving the perception of being calm, even if '*flustered underneath the surface*' (Mary). Participants alluded to the importance of presenting a professional image, reassuring to patients and their families, but the emotional toll of this is carried by team leading participants into their own time. Their rationale was, '*you are it*' (Jane), '*the buck stops with you*' (Mary).

Discussion

This study, of course, was conducted in a specific geographical location with a small sample of district nurses. Nonetheless, in-depth analysis of the experiences of these participants can shed light on the challenges that face community nurses in many parts of the world. The present findings enable insight into different district nursing roles, specifically those who have a team leading and management remit and those in advanced practitioner roles, whose focus is on care management as part of a multidisciplinary team. The depth of insight in the present study revealed aspects of the role not previously found in the literature. The burden of responsibility felt particularly by team leading community nurses, resonates with some previous studies, but there is no recent work focusing on the topic. Similar to findings in a small study by Haycock-Stuart, Kean and Baggley (2010), juggling clinical and administrative responsibilities for district nurses in this study, was a significant stressor. There was a sense of separateness of these two aspects of practice and the need to take unilateral decisions, rather than sharing responsibility with the team was evident. The ‘unboundaried’ nature of the caseload was similarly identified as a stressor, resonating with Haycock-Stuart, Kean and Baggley’s (2010) study, where participants had no control over admissions or size of their caseload. In this study, the responsibility district nurses felt for striking a balance between promoting patient autonomy and risk management, compounded by a lack of resources and a sense of not being able to provide the care for people to enable them to stay at home added to their stress. Similarly was the remoteness of care-giving contexts and teams. Some team members were unknown to the leader because of different services and employers. Although feeling burdensome, these stressors may have been the motivation for creativity in problem-solving and their efforts in ‘going the extra mile’. Interestingly this was not recognised by participants themselves.

Participants described their leadership as being like the conductor of the orchestra, illustrating the range of styles they adopt in the different aspects of their role. Work by Carnicer et al. (2015) describes orchestral conductors' different leadership styles which they suggest are dependent on context. During rehearsals, they are directors and teachers, whilst during concerts they are mediators and coaches, facilitating a better understanding of the music for the audience. They use themselves and convey their feelings openly through expression. Facilitative styles were evident for participants in this study when working 'in concert' with patients and families, helping them to remain at home, avoiding unnecessary hospital admissions. A directive style emerged however whilst managing the team and the caseload, perhaps preparing for the 'main event' of care giving. Carnicer et al. (2015) describe the importance of visibility of the conductor to ensure there is multi-directional communication with the orchestra. However, this need for visibility may be a barrier for team leading district nurses to adopt a more facilitative style within remote teams. It may contribute to feeling the need to juggle two distinct and competing parts of their role.

According to leadership theory, directive leadership maintains the status quo and is a way of maintaining position power (Northouse, 2016). Although, in this study, the approach appeared less about exerting power but may have been due to a commitment of support to teams. This commitment was also identified in previous studies (Cameron, et al. 2012; Gustafsson et al. 2010) where being supportive was viewed as unconditional in the Swedish study and a 'quasi-family' in the UK study. Both studies suggesting the importance of support for empowerment. Empowerment is key to transformational leadership, the leadership approach often cited in nursing literature. This relational approach has positive impacts on positive outcomes for patients and staff (Asif et al. 2019; Boamah, et al. 2018). However, the challenges encountered in

settings where the day-to-day demands of service provision are not readily compatible with principles of transformational leadership make such leadership very difficult to achieve (Fast & Rankin, 2018). It is for such reasons that previous writers have argued for a model of nursing leadership that takes greater account of the challenges that nurses do face in everyday provision of care (Hutchinson & Jackson, 2013). Contemporary relational models, such as compassionate and person-centred leadership appear to reduce workplace stress, increased staff autonomy and encourage innovation (Cardiff, McCormack & McCance, 2018; West, Eckert, Collins & Chowla, 2017). They advocate sharing responsibility through enabling others' autonomy, but this is not written about in the community nursing literature. It is however, a feature of Magnet Hospitals, which is well documented. In this model of healthcare, principles of accountability, partnership, ownership, and equity feature can be evidenced (Kelly et al. 2017). Re-focusing district nursing expertise in reaching shared responsibilities with patients therefore, may offer a way of easing the burden. The opportunities in using relationships to share responsibility were discussed by Brinkman (2014), a nurse advisor from New Zealand, although this was within contemporary therapeutic relationships. She describes how healthcare professionals strive to reach a balance of rights and responsibilities with patients and suggests shared responsibility can be achieved if there is mutuality, reciprocity and a focus on personal resourcefulness. She even suggests taking on unwarranted responsibility may not be in the patients' best interest and can evoke stressors. Adopting the same focus with teams, may help ease the burden of responsibility felt by district nurses and may also promote autonomy.

The need for nursing leadership in community nursing at all levels was identified in a recent study by Jarrin et al. (2019) where international priorities for education, practice and practice were identified by 50 leaders in home care in 17 countries. The resultant call to action

was to develop leadership, particularly skills in care coordination, advocacy and empowering patients and families to be active team members. Although these home care leaders did not specify skills in empowering teams, this is a key concept in contemporary leadership models and is vital as the WHO (2016) calls for more enabling workplaces. They suggest nurses should be equipped with knowledge, strategies and strength to lead and manage nursing through change and into a healthier future for all populations (International Council of Nurses, 2010, p.9). However, organisational expectation that community nurses demonstrate leadership appears variable in the literature (Cameron et al. 2012; Gustafsson et al. 2010). Similarly, in this study, empowerment was only described in the team context by one district nurse. She managed the largest team. She described engaging team members and participating in decision-making from a distance, enabling team members increasingly to be comfortable in making their own decisions about care management.

Garcia-Sierra & Fernandez-Castro (2018) used Kanter's (1993) theory of structural empowerment to explore supportive workplaces with healthcare leaders across settings, including primary care in one organisation in Spain. They revealed leadership as an influencing factor and suggest relational leadership increases engagement. District nurses can create enabling workplaces by using existing attributes and skills. This may be the way to reduce the burden of responsibility, promote engagement and autonomy and share leadership which according to West and colleagues (West et al., 2017) would improve patient outcomes. However, participants in this study did not appear to experience empowerment themselves or create empowering workplaces. The conditions for empowerment they were able to create appeared limited to their work with patients and families. Translating their approach of enabling and sharing responsibility with patients and families, could, if re-focussed also contribute in

promoting autonomy within the team. Creating conditions for empowerment could also ease the burden of responsibility felt by community nurses. It could aid developing a competent, motivated and empowered workforce to deliver quality care as advocated in the 2016 WHO Global Strategy on Human Resources for Health: Workforce 2030.

This study raises the importance of context and the impact it can have on community nurses' well-being and perceptions of their role. The findings may have implications for community nurses in other countries, particularly where services are developing, teams are growing to meet the increased demand of caring for people in the community. In the absence of professional development, recruitment and retention of nurses across the globe will remain challenging and the WHO (2016) commitment to keep people at home or as close to home as possible will be difficult to achieve. The clinical importance of this paper is leadership development across all levels of healthcare is a policy imperative and this study suggests there is un-tapped potential in the community nurse workforce. If community nurses are encouraged to view their role in a more integrated way and re-focus their skills in care management through a lens of leadership, they would be in a position to create conditions of empowerment. Models of leadership can increase team effectiveness, well-being and patient outcomes. It may reduce workload stress experienced by community nurses. This study may influence the way district nurse leadership is viewed and supported by practice, managers and educators

References

- Aryee, S., Chen, Z X., & Debrah, Y.A. 2007. Antecedents and outcomes of abusive supervision: Test of a trickle-down model. *Journal of Applied Psychology*, 92:191–201.
<https://doi.org/10.1037/0021-9010.92.1.191>
- Asif, M., Jameel, A., Hussain, A., Hwang, J., & Sahito, N. 2019. Linking Transformational Leadership with Nurse-Assessed Adverse Patient Outcomes and the Quality of Care: Assessing the Role of Job Satisfaction and Structural Empowerment. *Int J Envir Res & Pub Health*, 16(13). <https://doi.org/10.3390/ijerph16132381>
- Boamah, SA., Spence Laschinger, HK., Wong, C., & Clarke, S. 2018. Effect of transformational leadership on job satisfaction and patient safety outcomes. *Nursing Outlook*, 66:180–189.
<https://doi.org/10.1016/j.outlook.2017.10.004>
- Brinkman, A. 2014. Balancing rights with responsibilities. *Kai Tiaki Nurs NZ*, 20(9):38-30.
- Cameron, S., Harbison, J., Lambert, V., & Dickson, C. 2012. Exploring leadership in community nursing teams. *JAN*, 68:1469-1481. <http://dx.doi.org/10.1111/j.1365-2648.2011.05869.x>
- Cardiff, S. McCormack, B., & McCance, T. 2018. Person-centred leadership: A relational approach to leadership derived through action research. *JCN*, 27:3056-3069.
<https://doi.org/10.1111/jocn.14492>
- Carlin, A., & Chesters, A. 2019. Future of Specialist Practice Qualifications in district nursing for band 6 leadership roles. *BJCN*, 24:10–15. doi:10.12968/bjcn.2019.24.1.10
- Carnicer, JG, Garrido, DC. & Requena, SO. 2015. Music and leadership: the role of the conductor. *Int. J Mus & Perform Arts*, 3:84-88. <http://dx.doi.org/10.15640/ijmpa.v3n1a8>
- Currie, E.J., & Hill, RA. 2012. What are the reasons for high turnover in nursing? A discussion of presumed causal factors and remedies. *Int J Nurs Stud*, 49:1180–1189.

<https://doi.org/10.1016/j.ijnurstu.2012.01.001>

Fast, O., & Rankin, J. 2018. Rationing nurses: Realities, practicalities, and nursing leadership theories. *Nurs Inq*, 25(2), e12227.

Garcia-Sierra, R & Fernandez-Castro, J. 2018. Relationships between leadership, structural empowerment and engagement in nurses. *JAN*, 74:2809-2819.

Gustafsson, C., Fagerberg, I., & Asp, M. 2010. Supportive leadership in Swedish community night nursing. *J Nurs Man*, 18:822–831. <https://doi.org/10.1111/j.1365-2834.2010.01155.x>

Haycock-Stuart, E. A., Kean, S., & Baggley, S., 2010. Emotional labour within community nursing leadership *Comm Pract*. 83(9):24-28.

Health & Care Professions Council 2016. *Standards of Conduct, Performance and Ethics*.

London: HCPC. Available at: <https://www.hcpc-uk.org/globalassets/resources/standards/standards-of-conduct-performance-and-ethics.pdf>

Heidegger, M. 1995. *Being and time*. Translated from the German by Macquarrie, J. and Robinson, E. Oxford: Blackwell.

Hutchinson, M., & Jackson, D. 2013. Transformational leadership in nursing: towards a more critical interpretation. *Nurs Inq*, 20:11-22.

International Centre for Human Resources in Nursing Reforming Primary Health Care: a nursing perspective 2012. Available at:

<http://www.icchnr.org/documents/PHCNursing.pdf>

Jarrin, OF., Ali Poulad, F., & Madigan, E. 2019. International priorities for home care education, research, practice, and management: Qualitative content analysis. *Nurs Ed Today*, 73:83-87. <https://doi.org/10.1016/j.nedt.2018.11.020>

Kanter, R. M. 1993. *Men and Women of the Corporation* (2nd ed.). New York, NY: Basic Books.

Kean, S., Haycock-Stuart, E., Baggley, S., & Carson, M., 2011. Followers and the co-construction of leadership. *Journal of Nursing Management*, 19:507-516.

doi:[10.1111/j.1365-2834.2011.01227.x](https://doi.org/10.1111/j.1365-2834.2011.01227.x)

Kelly, LA., McHugh, MD., Aitken, LH. 2012. Nurse outcomes in Magnet and non-Magnet Hospitals. *J Nurs Admin*. 42:S44–S49. doi:10.1097/01.NNA.0000420394.18284.4f

Maybin, J., Charles, A., & Honeyman, M. 2016. *Understanding Quality of District Nursing Services*. London: Kings Fund. Available at:

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/quality_district_nursing_aug_2016.pdf

Mosadeghrad, M. 2014. Factors influencing healthcare service quality. *Int J Health Pol*, 3:77-89. doi: [10.15171/ijhpm.2014.65](https://doi.org/10.15171/ijhpm.2014.65)

Nicholl, H. 2010. Diaries as a method of data collection in research. *Nurs Res*. 22:16-20.

Northouse, P. G. 2016. *Leadership: Theory and Practice* (7th ed.). Thousand Oaks, CA: Sage Publications.

Smith, JA. 2007. *Qualitative Psychology: A Practical Guide to Research Methods*, London: Sage.

Smith, J., Flowers, P. & Larkin, M. 2009. *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage.

Smith, JA., & Osborn M. 2008. Interpretative phenomenological analysis. In J.A. Smith (Ed.) *Qualitative Psychology: A Practical Guide to Methods* London: Sage.

Stanley, D. 2014.. Clinical leadership characteristics confirmed. *J Res Nurs*, 19:118–128. <https://doi.org/10.1177/0969646214531111>

doi.org/10.1177/1744987112464630

Twigg, D., & McCullough, K. 2011). Nurse retention: A review of strategies to create and enhance positive practice environments in clinical settings. *Int J Nurs Stud*, 51:85–92.

<https://doi.org/10.1016/j.ijnurstu.2013.05.015>

van Iersel, M., Latour, CHM., van Rijn, M., de Vos, R., Kirschner, PA., & Scholte op Reimer, WJM. (2018). Factors underlying perceptions of community care and other healthcare areas in first-year baccalaureate nursing students: A focus group study. *Nurs Ed Today*, 66:57–62. <https://doi.org/10.1016/j.nedt.2018.04.004>

Watters, S. 2009. Shared leadership: taking flight. *Journal. Nursing Administration*, 39:26-29. doi: 10.1097/NNA.0b013e31818fe7a8

West, M., Eckert, R., Collins, B., & Chowla, R. 2017. *Caring to Change: How compassionate leadership can stimulate innovation in healthcare*. Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Caring_to_change_Kings_Fund_May_2017.pdf

World Health Organisation 2016. *Global Strategy on Human Resources for Health: Workforce 2030*. Available at: <https://apps.who.int/iris/bitstream/handle/10665/250368/9789241511131-eng.pdf?sequence=1&ua=1>

While, A. 2016. Nurturing ethical leadership. *BJCN* 21:534. <https://doi.org/10.12968/bjcn.2016.21.10.534>

World Health Organization Positive Practice Environments Campaign Retrieved from: <https://www.who.int/workforcealliance/about/initiatives/ppe/en/>

Yardley, L. 2008. Demonstrating validity in qualitative psychology. In J.A. Smith (Ed),

Qualitative Psychology: A practical guide to methods London: Sage.